CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospitals and Provider Operations

(Amended after Comments)

907 KAR 1:825. Diagnosis-related group (DRG) inpatient hospital reimbursement.

RELATES TO: KRS 13B.140, 205.510(16), 205.565, 205.637, 205.638, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.201(c), 447.250-447.280, 42 U.S.C. 1395f(l), ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.205.640(1), 205.641(2), 216.380(12), 42 C.F.R. 447.200, 447.250, 447.252, 447.253, 447.271, 447.272, 42 U.S.C. 1396a, 1396r-4

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining the amount payable via a diagnosis-related group methodology by the Medicaid Program for a hospital inpatient service including provisions necessary to enhance reimbursement pursuant to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

(2) “Adjustment factor” means the factor by which non-neonatal care relative weights shall be reduced to offset the expenditure pool adjustment necessary to enhance neonatal care relative weights.

(3) “Appalachian Regional Hospital System” means a private, not-for-profit hospital chain operating in a Kentucky county that receives coal severance tax proceeds.

(4) "Base rate" means the per discharge hospital-specific DRG rate for an acute care hospital that is multiplied by the relative weight to calculate the DRG base payment.

(5) "Base year" means the state fiscal year period used to establish DRG rates.

(6) “Base year Medicare rate components” means Medicare inpatient prospective payment system rate components in effect on October 1 during the base year as listed in the CMS IPPS Pricer Program.

(7) “Budget neutrality” means that reimbursements resulting from rates paid to providers under a per discharge methodology do not exceed payments in the base year adjusted for inflation based on the CMS Input Price Index or changes in patient utilization.

(8) "Budget neutrality factor" means a factor that is applied to a DRG base rate or the direct graduate medical educational payment so that budget neutrality is achieved.

(9) “Capital cost” means capital related expenses including insurance, taxes, interest and depreciation related to plant and equipment.

(10) “CMS” means the Centers for Medicare and Medicaid Services.

(11) “CMS IPPS Pricer Program” means the software program published on the CMS website of http://www.cms.hhs.gov which shows the Medicare rate components and

payment rates under the Medicare inpatient prospective payment system for a discharge within a given federal fiscal year.

(12) “Cost center specific cost-to-charge ratio” means a ratio of a hospital’s cost center specific total hospital costs to its cost center specific total charges.

(13) “Cost outlier” means a claim for which estimated cost exceeds the outlier threshold.

(14) "Critical access hospital" or "CAH" means a hospital meeting the licensure requirements established in 906 KAR 1:110 and is designated as a critical access hospital by the department.

(15) "Department" means the Department for Medicaid Services or its designated agent.

(16) “Diagnostic categories” means the diagnostic classifications containing one or more DRGs used by Medicare programs, assigned in the base year with modifications established in Section 2(15) of this administrative regulation.

(17) "Diagnostic related group" or "DRG" means a clinically-similar grouping of services that can be expected to consume similar amounts of hospital resources.

(18) "Distinct part unit" means a separate unit within an acute care hospital that meets the qualifications established in 42 C.F.R. 412.25 and is designated as a distinct part unit by the department.

(19) “DRG average length of stay” means the Kentucky arithmetic mean length of stay for each DRG, calculated by dividing the sum of patient days in the base year claims data for each DRG by the number of discharges for each DRG.

(20) “DRG base payment” means the base payment for claims paid under the DRG

methodology.

(21) “Enhanced neonatal care relative weight” means a neonatal care relative weight increased, with a corresponding reduction to non-neonatal care relative weights, to facilitate reimbursing neonatal care at 100% of costs in aggregate by category.

(22) “Federal financial participation” **is defined in 42 CFR 400.203[~~means funding from the Centers for Medicare and Medicaid Services~~]**.

(23) "Fixed loss cost threshold" means the amount, equal to $29,000, which is combined with the full DRG payment or transfer payment for each DRG to determine the outlier threshold.

(24) “Geometric mean” means the measure of central tendency for a set of values expressed as the n^{th} (number of values in the set) root of their product.

(25) “GII” means Global Insight, Incorporated.

(26) "Government entity" means an entity that qualifies as a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

(27) “High intensity level II neonatal center” means an in-state hospital with a level II neonatal center which:

(a) Is licensed for a minimum of twenty-four (24) neonatal level II beds;

(b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;

(c) Has a gestational age lower limit of twenty-seven (27) weeks; and

(d) Has a full-time perinatologist on staff.

(28) “High volume per diem payment” means a per diem add-on payment made to hospitals meeting selected Medicaid utilization criteria established in Section 2(12) of this administrative regulation.

(29) "Indexing factor" means the percentage that the cost of providing a service is expected to increase during the universal rate year.

(30) "Inflation factor" means the percentage that the cost of providing a service has increased, or is expected to increase, for a specific period of time.

(31) "Intrahospital transfer" means a transfer within the same acute care hospital resulting in a discharge from and a new admission to a licensed and certified acute care bed, psychiatric distinct part unit, or rehabilitation distinct part unit.

(32) “Level I neonatal center” means a facility with a licensed level I bed which provides care to newborn infants of a more intensive nature than the usual nursing care provided in newborn acute care units, on the basis of physicians’ orders and approved nursing care plans.

(33) "Level II neonatal center" means a facility with a licensed level II bed which provides specialty care for infants which includes monitoring for apnea spells, incubator or other assistance to maintain the infant’s body temperature, and feeding assistance.

(34) "Level III neonatal center" means a facility with a licensed level III bed which provides specialty care of infants which includes ventilator or other respiratory assistance for infants who cannot breathe adequately on their own, special intravenous catheter to monitor and assist blood pressure and heart function, observation and monitoring of conditions that are unstable or may change suddenly, and postoperative care.

(35) "Long-term acute care hospital" means a hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(36) “Low intensity level III neonatal center” means a facility with fewer than four (4) licensed level III neonatal beds.

(37) "Medicaid shortfall" means the difference between a provider's cost of providing services to Medicaid recipients and the amount received in accordance with the payment provisions established in Section 2 of this administrative regulation.

(38) "Medical education costs" means direct costs that are:

(a) Associated with an approved intern and resident program; and

(b) Subject to limits established by Medicare.

(39) "Medically necessary" or "medical necessity" means that a covered benefit shall be provided in accordance with 907 KAR 3:130.

(40) "Outlier threshold" means the sum of the DRG base payment or transfer payment and the fixed loss cost threshold.

(41) "Pediatric teaching hospital" is defined in KRS 205.565(1).

(42) "Per diem rate" means the per diem rate paid by the department for inpatient care in an in-state psychiatric or rehabilitation hospital, inpatient care in a long-term acute care hospital, inpatient care in a critical access hospital or psychiatric or rehabilitation services in an in-state acute care hospital which has a distinct part unit.

(43) "Psychiatric hospital" means a hospital which meets the licensure requirements as established in 902 KAR 20:180.

(44) "Quality improvement organization" or "QIO" means an organization that complies with 42 C.F.R. 475.101.

(45) "Rebase" means to re-determine base rates, per diem rates, and other applicable components of the payment rates using more recent data.

(46) "Rehabilitation hospital" means a hospital meeting the licensure requirements as established in 902 KAR 20:240.

(47) "Relative weight" means the factor assigned to each Medicare DRG classification that represents the average resources required for a Medicare DRG classification relative to the average resources required for all relevant discharges in the state.

(48) "Resident" means an individual living in Kentucky who is not receiving public assistance in another state.

(49) “Rural hospital” means a hospital located in a rural area pursuant to 42 CFR 412.64(b)(1)(C).

(50) "State university teaching hospital" means:

(a) A hospital that is owned or operated by a Kentucky state-supported university with a medical school; or

(b) A hospital:

1. In which three (3) or more departments or major divisions of the University of Kentucky or University of Louisville medical school are physically located and which are used as the primary (greater than fifty (50) percent) medical teaching facility for the medical students at the University of Kentucky or the University of Louisville; and

2. That does not possess only a residency program or rotation agreement.

(51) “Transfer payment” means a payment made for a recipient who is transferred to or from another hospital for a service reimbursed on a prospective discharge basis.

(52) "Trending factor" means the inflation factor as applied to that period of time between a facility’s base fiscal year end and the beginning of the universal rate year.

(53) "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School.

(54) "Universal rate year" means the twelve (12) month period under the prospective payment system, beginning July of each year, for which a payment rate is established for a hospital regardless of the hospital's fiscal year end.

(55) "Urban hospital" means a hospital located in an urban area pursuant to 42 CFR 412.64(b)(1)(ii).

(56) "Urban trauma center hospital" means an acute care hospital that:

(a) Is designated as a Level I Trauma Center by the American College of Surgeons;

(b) Has a Medicaid utilization rate greater than twenty-five (25) percent; and

(c) At least fifty (50) percent of its Medicaid population are residents of the county in which the hospital is located.

Section 2. Payment for an Inpatient Acute Care Service in an In-state Acute Care Hospital. (1) An in-state acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis.

(2) For an inpatient acute care service in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:

(a) A DRG base payment;

(b) If applicable, a high volume per diem payment; and

(c) If applicable, a cost outlier payment amount.

(3)(a) A DRG shall be based on the Medicare grouper in effect in the Medicare inpatient prospective payment system at the time of rebasing.

(b) For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data, DRG classifications from Medicare grouper version twenty-four (24) effective in the Medicare inpatient prospective

payment system as of October 1, 2006.

(4) A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.

(5)(a) The department shall determine a base rate by calculating a case mix, outlier payment and budget neutrality adjusted cost per discharge for each in-state acute care hospital as described in subsection (5) through (10) of this Section.

(b) A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.

(c) For a rate effective upon the effective date of this administrative regulation, a hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.

(6)(a) The department shall calculate a cost to charge ratio for the fifteen (15) Medicaid and Medicare cost centers displayed in Table 1 below.

(b) If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk		
Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost Center

1	Routine Days	25
2	Intensive Days	26, 27, 28, 29, 30
3	Drugs	48, 56
4	Supplies or equipment	55, 66, 67
5	Therapy services excluding inhalation therapy	50, 51, 52
6	Inhalation therapy	49
7	Operating room	37, 38
8	Labor and delivery	39
9	Anesthesia	40
10	Cardiology	53, 54
11	Laboratory	44, 45
12	Radiology	41, 42
13	Other services	43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68
14	Nursery	33
15	Neonatal intensive days	30

(7)(a) For a hospital with an intern or resident reported on its Medicare cost report, the department shall calculate allocated overhead by computing the difference between the costs of interns and residents before and after the allocation of overhead costs.

(b) The ratio of overhead costs for interns and residents to total facility costs shall be

multiplied by the costs in each cost center prior to computing the cost center cost-to-charge ratio.

(8) For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days and total charges from the base year claims data. The department shall exclude from the rate calculation:

(a) Claims paid under a managed care program;

(b) Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;

(c) Transplant claims; and

(d) Revenue codes not covered by the Medicaid program.

(9)(a) The department shall calculate the cost of a base year claim by multiplying the charges from each accepted revenue code by the corresponding cost center specific cost-to-charge ratio.

(b) The department shall base cost center specific cost-to-charge ratios on data extracted from the most recently, as of June 1, finalized cost report.

(c) Only an inpatient revenue code recognized by the department shall be included in the calculation of estimated costs.

(10) Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute a hospital specific cost per discharge by dividing a hospital's Medicaid costs by its number of Medicaid discharges.

(11) The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's specific cost per discharge by the hospital's case mix, expected outlier payments and budget neutrality.

(a)1. A hospital's case mix adjusted cost per discharge shall be calculated by dividing the hospital's cost per discharge by its case mix index; and

2. The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in subsection (8) of this Section.

(b)1. A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.

2. The initial budget neutrality factor for a rate shall be 0.6962 for all hospitals.

3. When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

(c)1. Each hospital's case mix and initial budget neutrality adjusted cost per discharge shall be multiplied by a hospital-specific outlier payment factor.

2. A hospital-specific outlier payment factor shall be the result of the following formula: ((expected DRG non-outlier payments) – (expected proposed DRG outlier payments))/(expected DRG non-outlier payments).

(d)1. A hospital's case mix, initial budget neutrality and outlier payment adjusted cost per discharge shall be multiplied by a secondary budget neutrality factor.

2. The secondary budget neutrality factor for a hospital shall be 1.0744.

3. When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in pa-

tient volume and case mix.

(12)(a) The department shall make a high volume per diem payment to an in-state acute care hospital with high Medicaid volume for base year covered Medicaid days referenced in subsection (8) of this Section.

(b) High volume per diem criteria shall be based on the number of Kentucky Medicaid days or the hospital's Kentucky Medicaid utilization percentage.

(c)1. A high volume per diem payment shall be made in the form of a per diem add-on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.

2. The payment shall be equal to the applicable high volume per diem add-on amount multiplied by the DRG average length-of-stay associated with the claim's DRG classification.

(d)1. The department shall determine a per diem payment associated with Medicaid days-based criteria separately from a per diem payment associated with Medicaid utilization-based criteria.

2. If a hospital qualifies for a high volume per diem payment under both the Medicaid days-based criteria and the Medicaid utilization-based criteria, the department shall pay the higher of the two add-on per diem amounts.

(e) The department shall pay the indicated high volume per diem payment if either the base year covered Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization percent meet the criteria established in Table 2 below:

Table 2 – High Volume Adjustment Eligibility Criteria

Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
0 – 3,499 days	$0 per day	0.0% - 13.2%	$0.00 per day
3,500 – 4,499 days	$22.50 per day	13.3% - 16.1%	$22.50 per day
4,500 – 7,399 days	$45.00 per day	16.2% - 21.6%	$45.00 per day
7,400 – 10,999 days	$129.00 per day	21.7% - 27.2%	$81.00 per day
11,000 – 19,999 days	$172.00 per day	27.3% - 100.00%	$92.75 per day
20,000 and above days	$306.00 per day		

(f) The department shall use base year claims data referenced in subsection (8) of this Section to determine if a hospital qualifies for a high volume per diem add-on payment.

(g) The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

(13)(a) The department shall make an additional cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each diagnostic category.

(b) A cost outlier shall be subject to QIO review and approval.

(c) A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.

(d)1. The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

2. A Medicare operating or capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.

(e)1. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

2. The fixed loss cost threshold shall equal $29,000.

(f) A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

(14) The department shall calculate a Kentucky Medicaid-specific DRG relative weight by:

(a)1. Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this Section; and

2. For a rate effective upon the effective date of this administrative regulation, a hospital-specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data;

(b)1. Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing; and

2. For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data the Medicare grouper version 24 DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;

(c) Removing the following claims from the calculation:

1. Claims data for a discharge reimbursed on a per diem basis including:

a. A psychiatric claim, defined as follows:

(i) An acute care hospital claim with a psychiatric DRG;

(ii) A psychiatric distinct part unit claim; and

(iii) A psychiatric hospital claim;

b. A rehabilitation claim, defined as follows:

(i) An acute care hospital claim with a rehabilitation DRG;

(ii) A rehabilitation distinct part unit claim; and

(iii) A rehabilitation hospital claim;

c. A critical access hospital claim; and

d. A long term acute care hospital claim;

2. A transplant service claim as specified in subsection (19) of this Section;

3. A claim for a patient discharged from an out-of-state hospital; and

4. A claim with total charges equal to zero (0);

(d) Calculating a relative weight value for a low volume DRG by:

1.a. Arraying a DRG with less than twenty-five (25) cases in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system at the same time as the Medicare DRG grouper version, published in the Federal Regis-

ter, relied upon for Kentucky DRG classifications; and

b. For a rate rate effective upon the effective date of this administrative regulation, the department shall use the Medicare DRG relative weight which was effective in the Medicare inpatient prospective payment system as of October 1, 2006;

2. Grouping a low volume DRG, based on the Medicare DRG relative weight sort, into one (1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;

3. Calculating a DRG relative weight for each category; and

4. Assigning the relative weight calculated for a category to each DRG included in the category;

(e)1. Standardizing the labor portion of the cost of a claim for differences in wage and the full cost of a claim for differences in indirect medical education costs across hospitals based on base year Medicare rate components;

a. For a rate effective upon the effective date of this administrative regulation, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and

b. Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:

(i) Labor-related percentage and non-labor-related percentage;

(ii) Operating and capital cost-to-charge ratios;

(iii) Operating indirect medical education costs; or

(iv) Wage indices;

2.a. The department shall standardize costs using the following formula: standard

cost = [((labor related percentage X costs)/Medicare wage index) + (non-labor related percentage X costs)]/(1 + Medicare operating indirect medical education factor); and

b. For a rate effective upon the effective date of this administrative regulation, the labor related percentage shall equal sixty-two (62) percent and the non-labor related percentage shall equal thirty-eight (38) percent;

(f) Removing statistical outliers by deleting any case that is:

1. Above or below three (3) standard deviations from the mean cost per discharge; and

2. Above or below three (3) standard deviations from the mean cost per day;

(g) Computing an average standardized cost for all DRGs in aggregate and for each DRG, excluding statistical outliers;

(h) Computing DRG relative weights:

1. For a DRG with twenty-five (25) claims or more by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and

2. For a DRG with less than twenty-five (25) claims by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge;

(i) Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG based on the base year claims data used to calculate DRG relative weights;

(j) Employing enhanced neonatal care relative weights;

(k) Applying an adjustment factor to relative weights not referenced in paragraph (j) of this subsection to offset the level I, II and III neonatal care relative weight increase

resulting from the use of enhanced neonatal care relative weights; and

(l) Excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal care relative weight calculations.

(15) The department shall:

(a) Separately reimburse for a mother's stay and a newborn's stay based on the diagnostic category assigned to the mother's stay and to the newborn's stay;

(b) Establish a unique set of diagnostic categories and relative weights for an in-state acute care hospital identified by the department as qualifying as a level I, II or III neonatal center as follows:

1. The department shall exclude high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calculations;

2. The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:

a. DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and

b. DRG 685-690 for an in-state acute care hospital with a level III neonatal center;

3. The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and

4.a. The department shall compute a separate relative weight for a level II or III neonatal intensity care unit (NICU) neonatal DRG;

b. The department shall use base year claims from level II neonatal centers, excluding claims from any high intensity level II neonatal center, to calculate relative weights

for DRGs 675-680; and

c. The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.

(16) The department shall expend in aggregate by category (level I, II or III neonatal center category) and not by individual facilities:

(a) A total expenditure for level I neonatal center care equal to 100% of cost;

(b) A total expenditure for level II neonatal center care equal to 100% of cost; or

(c) A total expenditure for level III neonatal center care equal to 100% of cost.

(17) The department shall reimburse an individual:

(a) Level I neonatal center for level I neonatal care at the average cost per DRG of all level I neonatal centers;

(b) Level II neonatal center for level II neonatal care at the average cost per DRG of all level II neonatal centers; or

(c) Level III neonatal center for level III neonatal care at the average cost per DRG of all level III neonatal centers.

(18) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

(a) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

1. The department shall calculate an average daily rate by dividing the DRG base

payment by the statewide Medicaid geometric mean length-of-stay for a patient's DRG classification.

2. If a hospital qualifies for a high volume per diem add-on payment in accordance with Section 2(12) of this administrative regulation, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay.

3. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

(b) For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment, and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

(19) The department shall treat a transfer from an acute care hospital to a qualifying postacute care facility for selected DRGs in accordance with paragraph (b) of this subsection as a postacute care transfer.

(a) The following shall qualify as a postacute care setting:

1. A psychiatric, rehabilitation, children's, long-term, or cancer hospital;

2. A skilled nursing facility; or

3. A home health agency.

(b) A DRG eligible for a postacute care transfer payment shall be in accordance with 42 USC 1395ww(d)(4)(C)(i).

(c) The department shall pay each transferring hospital an average daily rate for each day of stay.

1. A payment shall not exceed the full DRG payment that would have been made if

the patient had been discharged without being transferred.

2. A DRG identified by CMS as being eligible for special payment shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay, up to the full DRG base payment.

3. The remaining DRGs as referenced in paragraph (b) of this subsection shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.

(d) The per diem amount shall be the base DRG payment allowed divided by the statewide Medicaid geometric mean length of stay for a patient's DRG classification.

(20) The department shall reimburse for an intrahospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit:

(a) The full DRG base payment allowed; and

(b) The facility-specific distinct part unit per diem rate, in accordance with 907 KAR 1:815, Non-DRG hospital reimbursement, for each day the patient remains in the distinct part unit.

(21)(a) The department shall reimburse for a kidney, cornea, pancreas, or kidney and pancreas transplant on a prospective per discharge method according to the patient's DRG classification.

(b) A transplant not referenced in paragraph (a) of this subsection, shall be reimbursed in accordance with 907 KAR 1:350, Coverage and payments for organ transplants.

Section 3. Preadmission Services for an Inpatient Acute Care Service. A preadmis-

sion service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

(1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and

(2) Exclude a service furnished by a home health agency, a skilled nursing facility or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Section 4. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs. (1) If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 CFR 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.

(2) If federal financial participation for direct graduate medical education costs is provided to the department, the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows:

(a) A payment shall be made:

1. Separately from the per discharge and per diem payment methodologies; and

2. On an annual basis; and

(b) The department shall determine an annual payment amount for a hospital as follows:

1. The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the uni-

versal rate year shall be provided by each approved hospital's Medicare fiscal intermediary;

2. The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected;

3. The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;

4. The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;

5. The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data to determine the total graduate medical education costs related to the Medicaid Program; and

6. Medicaid program graduate medical education costs shall then be multiplied by the budget neutrality factor.

Section 5. Budget Neutrality Factors. (1) When rates are rebased, estimated projected reimbursement in the universal rate year shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization.

(2) The estimated total payments for each facility under the reimbursement method-

ology in effect in the year prior to the universal rate year shall be estimated from base year claims.

(3) The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from base year claims.

(4) If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rate shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total adjusted payments in the year prior to the universal rate year.

Section 6. Reimbursement Updating Procedures. (1) The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.

(2) Except for an appeal in accordance with Section 18 of this administrative regulation, the department shall make no other adjustment.

(3) The department shall rebase DRG reimbursement every four (4) years.

Section 7. Use of a Universal Rate Year. (1) A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.

(2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

Section 8. Cost Reporting Requirements. (1) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report it

submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP–4 as follows:

(a) A cost report shall be submitted:

1. For the fiscal year used by the hospital; and

2. Within five (5) months after the close of the hospital's fiscal year; and

(b) Except as follows, the department shall not grant a cost report submittal extension:

1. If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.

(2) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

(3) A cost report submitted by a hospital to the department shall be subject to audit and review.

(4) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

Section 9. Unallowable Costs.

(1) The following shall not be allowable cost for Medicaid reimbursement:

(a) A cost associated with a political contribution;

(b)1. A cost associated with a legal fee for an unsuccessful lawsuit against the

Cabinet for Health and Family Services.

2. A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(c)1. A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity.

2. A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.

3. If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

(2) A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.

(3) The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

Section 10. Trending of a Cost Report for DRG Re-basing Purposes. (1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or unaudited, shall be trended to the beginning of the universal rate year to update a hospital's Medicaid cost.

(2) The department shall use the inflation factor prepared by GII as the trending factor for the period being trended.

Section 11. Indexing for Inflation. (1) After an allowable Medicaid cost has been

trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

(2) The department shall use the inflation factor prepared by GII as the indexing factor for the universal rate year.

Section 12. Readmission. (1) An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

(2) Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Section 13. Reimbursement for Out-of-state Hospitals. (1) The department shall reimburse an acute care out-of-state hospital, except for a children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state, for inpatient care:

(a) On a fully-prospective per discharge basis based on the patient's diagnostic category; and

(b) An all-inclusive rate.

(2) The all-inclusive rate referenced in subsection 1(b) of this section shall:

(a) Equal the facility-specific Medicare base rate multiplied by the Kentucky-specific DRG relative weights, except that the DRG relative weights shall exclude any adjustment for in-state hospitals pursuant to 2006 Ky. Acts ch. 252;

(b) Exclude:

1. Medicare indirect medical education cost or reimbursement;

2. High volume per diem add-on reimbursement;

3. Disproportionate share hospital distributions; and

4. Any adjustment mandated for in-state hospitals pursuant to 2006 Ky Acts ch. 252; and

(c) Include a cost outlier payment if the associated discharge meets the cost outlier criteria established in Section 2(13) of this administrative regulation;

1. The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim;

2. The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges;

3. The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year; and

4. The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

(3) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, an all-inclusive rate equal to the average all-inclusive base rate paid to in-state children's hospitals.

(4) An out-of-state provider shall not be eligible to receive high volume per diem add-

on payments, indirect medical education reimbursement or disproportionate share hospital payments.

(5) The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

(a) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.

(b) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.

(c) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

(d) The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold.

Section 14. Supplemental Payments. (1) Payment of a supplemental payment established in this section of this administrative regulation shall be contingent upon the department's receipt of corresponding federal financial participation.

(2) If federal financial participation is not provided to the department for a supplemental payment, the department shall not make the supplemental payment.

(3) In accordance with subsections (1) and (2) of this section, the department shall:

(a) In addition to a payment based on a rate developed under Section 2 of this administrative regulation, make quarterly supplemental payments to:

1. A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

a. Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

b. Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18);

2. A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

a. Equal to the difference between payments made in accordance with Sections 2, 3 and 4 of this administrative regulation and the amount allowable under 42 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;

b. That is prospectively determined with no end of the year settlement; and

c. Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph; and

3. A hospital that qualifies as an urban trauma center hospital in an amount:

a. Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

b. Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

c. That is prospectively determined with an end of the year settlement; and

d. That is consistent with the requirements of 42 C.F.R. 447.271.

(b) Make quarterly supplemental payments to the Appalachian Regional Hospital

system:

1. In an amount that is equal to the lesser of:

a. The difference between what the department pays for inpatient services pursuant to Section 2, 3 and 4 of this administrative regulation and what Medicare would pay for inpatient services to Medicaid eligible individuals; or

b. $7.5 million per year in aggregate;

2. For a service provided on or after July 1, 2005; and

3. Subject to the availability of coal severance funds, in addition to being subject to the availability of federal financial participation, which supply the state's share to be matched with federal funds;

(c) Base a quarterly payment to a hospital in the Appalachian Regional Hospital System on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System; and

(d) Make a supplemental payment to an in-state high intensity level II neonatal center of $2,870 per paid discharge for a DRG 675 – 680.

(4) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility.

(5) For the purpose of this section of this administrative regulation, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in 907 KAR 1:705.

(6) A payment made under this section of this administrative regulation shall not duplicate a payment made via 907 KAR 1:820.

(7) A payment made in accordance with this section of this administrative regulation shall be in compliance with the limitations established in 42 C.F.R. 447.272.

Section 15. Certified Public Expenditures. (1) The department shall reimburse an in-state public government-owned or operated hospital the full cost of an inpatient service via a certified public expenditure (CPE) contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

(2) To determine the amount of costs eligible for a CPE, a hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

(3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

(4)(a) Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

(b) If any difference remains, the department shall reconcile any difference with the provider.

Section 16. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

(1) The contract shall contain a provision granting the department access:

(a) To the subcontractor's financial information; and

(b) In accordance with 907 KAR 1:672; and

(2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

Section 17. New Provider, Change of Ownership, or Merged Facility.

(1) If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

(2)(a) Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.

(b) During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

(3) In the case of two (2) or more separate entities that merge into one (1) organization, the department shall:

(a) Merge the latest available data used for rate setting;

(b) Combine bed utilization statistics, creating a new occupancy ratio;

(c) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

(d) Compute on a weighted average the rate of increase control applicable to each entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting; and

(e)1. Require each provider to submit a cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.

2. A cost report for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 8 of this administrative regulation.

Section 18. **Federal Financial Participation. A provision established in this ad-**

ministrative regulation shall be effective contingent upon the department's receipt of federal financial participation for the respective provision.

Section 19. Appeals. (1) An administrative review shall not be available for the following:

(a) A determination of the requirement, or the proportional amount, of a budget neutrality adjustment in the prospective payment rate; or

(b) The establishment of:

1. Diagnostic related groups;

2. The methodology for the classification of an inpatient discharge within a DRG; or

3. An appropriate weighting factor which reflects the relative hospital resources used with respect to a discharge within a DRG.

(2) An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671.

Section **20[~~19~~]**. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) The "Supplemental Medicaid Schedule KMAP-1"; January 2007 edition; and

(b) The "Supplemental Medicaid Schedule KMAP-4", January 2007 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:825
(Amended after Comments)

REVIEWED:

Date

Elizabeth A. Johnson, Esq., Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:825
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Darlene Burgess (502) 564-6511

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the method for determining the amount payable by the Medicaid Program for care in an inpatient acute care hospital. The Department for Medicaid Services (DMS) shall employ a diagnosis-related group (DRG) methodology to reimburse for inpatient acute care. Previously one (1) administrative regulation established DMS reimbursement for DRG hospitals, per diem hospitals and disproportionate share hospital (DSH) distributions. DMS divided the one (1) administrative regulation into three (3) with this administrative regulation establishing DRG hospital reimbursement.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the payment methodology for inpatient hospital acute care.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the payment methodology for inpatient hospital acute care.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the payment methodology for inpatient hospital acute care.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This administrative regulation is a new administrative regulation; however, it amends policy by reimbursing in aggregate for level I, II and III neonatal care at 100% of costs; reimbursing individual level I, II or III neonatal centers at the average cost per DRG for the respective category and excluding high intensity level II neonatal center claims and low intensity level III neonatal center claims from the neonatal center relative weight calculations. The amendment after comments notes that provisions are contingent upon the provision of federal financial participation to the department.
(b) The necessity of the amendment to this administrative regulation: The amended policy is necessary to ensure adequate reimbursement of neonatal care in turn to ensure the adequate availability of such care for Medicaid recipients. The amendment after comments is necessary to maintain the viability of the Medicaid

program by clarifying that policies are contingent upon the provision of federal financial participation by the Centers for Medicare and Medicaid Services (CMS) to the department. CMS provides approximately seventy (70) percent of program funding to the department - compared to fifty (50) percent of administrative funding. The department, as part of its mission to serve the citizens of the Commonwealth of Kentucky in a fiscally responsible manner, must strive to ensure that program policies are contingent upon receipt of federal funding. Failure to maintain this safe guard would jeopardize the health, safety and welfare of recipients of Medicaid program services as well as impose an injurious and unsound financial burden on the citizens of Kentucky.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation conforms to the content of the authorizing statutes by preserving the viability of inpatient hospitals providing neonatal care in order to ensure the adequate availability of neonatal care for Medicaid recipients. The amendment after comments conforms to the content of the authorizing statutes by rendering policies contingent upon federal financial participation consistent with KRS 205.520(3).

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation assists in the effective administration of the statutes by preserving the viability of inpatient hospitals providing neonatal care in order to ensure the adequate availability of neonatal care for Medicaid recipient. The amendment after comments will assist in the effective administration of the authorizing statutes by rendering policies contingent upon federal financial participation consistent with KRS 205.520(3).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect all inpatient hospitals participating in the Kentucky Medicaid Program. Currently there are 105 in-state, inpatient hospitals participating in the Medicaid Program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The regulated entities will not be required to take any action to comply with the administrative regulation. Presumably they may educate staff regarding the reimbursement changes; however, no new requirements are mandated via this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Reimbursement for neonatal care is enhanced but as the funding source is a finite pool, other components of care may experience a reimbursement reduction.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Neonatal care reimbursement is increasing which in turn should

ensure the adequate availability of neonatal care for Medicaid recipients.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS projects the administrative regulation to be budget neutral as it re-distributes reimbursement within, rather than infuses additional monies into, the existing funding pool.
(b) On a continuing basis: DMS projects the administrative regulation to be budget neutral as it re-distributes reimbursement within, rather than infuses additional monies into, the existing funding pool.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, matching funds of general fund appropriations and hospital provider tax funds pursuant to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Out-of-state inpatient acute care hospital reimbursement, contrary to in-state acute care hospital reimbursement, shall not include provider tax enhancements as provider tax legislation only applies to in-state hospitals. Level I, II and III neonatal care shall be reimbursed, in aggregate, at 100% of costs in order to ensure the adequate availability of neonatal care for Medicaid recipients.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:825 Contact Person: Stuart Owen (502) 564-6204 or Darlene Burgess (502) 564-6511

1. Federal statute or regulation constituting the federal mandate.
   42 CFR Chapter 412, Chapter 413 and 447.200, 447.250, 447.271, and 447.272 address inpatient hospital reimbursement provisions.

2. State compliance standards.

   KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 addresses Medicaid reimbursement. 2006 Ky Acts ch. 252, KRS 142.303 and 205.638 address the utilization of hospital provider tax revenues to enhance inpatient hospital reimbursement.

3. Minimum or uniform standards contained in the federal mandate.

   Medicaid agency payments to providers must be sufficient to enlist enough providers so that Medicaid services are available to recipients at least to the same extent that comparable services are available to the general population. Payments for hospital services should be rates that the State finds, and makes assurances satisfactory to the United States Health and Human Services Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   This administrative regulation does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   This administrative regulation does not impose stricter, than federal, requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:825 Contact Person: Stuart Owen (502) 564-6204 or Darlene Burgess (502) 564-6511

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X_ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect county-owned hospitals as well as state university teaching hospitals.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by KRS 142.303, 205.520, 205.638, 2006 Ky Acts ch. 252, 42 CFR 412 and 413.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment is not expected to generate additional revenue for state or local government entities.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment is not expected to generate additional revenue for state or local government entities.

   (c) How much will it cost to administer this program for the first year? DMS projects the administrative regulation to be budget neutral as it re-distributes reimbursement within, rather than infuses additional monies into, the existing funding pool.

   (d) How much will it cost to administer this program for subsequent years? DMS projects the administrative regulation to be budget neutral as it re-distributes reimbursement within, rather than infuses additional monies into, the existing funding pool.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.